Community Hospital Task Force II
Meeting #4 Notes
December 19, 2007
Rhode Island Department of Labor and Training
Building 73, John O. Pastore Complex, Cranston, RI

Commissioner Koller called the meeting to order at and asked the task force members to identify themselves.

Commissioner Koller discussed Attachment 2 regarding the updated workplan for the task force. Commissioner Koller explained that the timing and the discussions by the group will likely mean that the January report will contain just the recommendation on the choice of the DRG grouper. Further, specific discussions will take place from January through March.

Discussion of the workplan by the task force

- Since outpatient payments make up a large portion of hospital revenues, is it prudent to look at inpatient and outpatient together. Kevin Quinn of ACS explained that methods of payment for inpatient and outpatient, while having the ability to be modeled on the same principles, are two very different processes. He said that while there is value in discussing inpatient and outpatient payment together, decisions should be made separately, since the technical details will be very different.

- A question was raised about whether Medicaid inpatient payment changes really help community hospitals. Commissioner Koller stated that the charge of the task force to look into Medicaid inpatient payment was a first step, and that other steps will follow.

- A question was raised about financial modeling and what factors the task force should consider when discussing the financial modeling. Factors to consider included the effect of a new system on physicians, the effect on access to care, and how a new system supports appropriate inpatient to outpatient transition.

- The task force discussed a letter written to the co-chairs by task force member Lou Giancola. The letter focused on a number of points, including addressing the fairness of outpatient payment system, the relevance of Medicaid inpatient to the challenges faced by the community hospitals, the applicability of the current work of the task force to commercial payers, the issues surrounding annual changes to the payment system, and models needed to address how payment rates are determined. Commissioner Koller discussed the issue of linkage of the work of the task force to the to commercial market. He stated that the recommended linkage between the two systems will be as strong as the task force wants it to be. United Healthcare stated that they prefer a case based system, but not all hospitals want to be paid on that system. Blue Cross Blue Shield asked whether it matters if a specific grouper is used by everyone or if a similar method of payment (like a case-rate) is appropriate.

- A question was raised about whether a temporary group is appropriate for decisions or if a more permanent group should be started to deal with issues of hospital payment on an ongoing basis. An argument for a more permanent group is that that group can take a long-term perspective.

A New Principle

On a recommendation by a task force member, Commissioner Koller proposed a new principle for the task force - "A method of payment used by all and applied by all." Koller continued that the level of consistency across payers is an issue to be determined by the Task Force.

Agreement on DRG Grouper

Kevin Quinn from ACS again highlighted the different options for a DRG grouper.

Points raised about the different DRG groupers:

- MS-DRGs are good for Medicare patients, but it takes a lot of work to customize them for other populations.
- APS-DRGs are like MS-DRGs that have already been customized for an all-patient population.
- APR-DRGs are the state of the art for an all-patient population. Maryland has used them for 3-4 years, and MA, MS, MT, and PA are all switching to that grouper.

The task force agreed that because it is up-to date and would require few, if any, carveouts for special services, the APR-DRG system is the best choice for Rhode Island Fee for Service Medicaid inpatient hospital payment.

Discussion of future modeling under APR-DRG grouper
Task Force requested models of how payment for past claims would have changed under a new APR-DRG, by service line, by pay-to-cost ratios (i.e., margin for different service lines), and by hospitals.

Public Comment

Commissioner Koller opened the floor for public comment.

Craig Syata, Hospital Association of RI:
Concerned with timeline, as it is clear that there is a lot of work to complete. He requested that the task force specifically recommend is their report that no changes to payment system be included in the budget submission for state fiscal year 2009. The suggestion that a new system be implemented by April of 2009 is too aggressive, and would also fall into the middle of hospitals' fiscal years, with little guidance on how to budget for the change.

Tom Gough, Memorial Hospital of Rhode Island:
The changes being recommended are major shifts in policy and not every institution has a voice in the discussion. Other states do financial simulations before decisions are made, and the task force have not seen any financial models. The task force does not know if a DRG system would take money out of the system. Even if it does not take money out, it has the potential to shift money from one institution to another which could exacerbate the financial problems for community hospitals. A DRG system shifts the risk of a patient's cost of care from the insurer to the hospital, and is that where the task force wants the risk?

Mark Crevier, Kent County Hospital:
Having the majority of payers on the same system is on the right track, but a case based rate needs to work well.

Question from audience: Does the Office of the Health Insurance Commissioner have the authority to mandate payment method used by commercial insurers? Answer is no, legislation would be needed.

Commissioner Koller stated that the next meeting would be to discuss the interim report to the Governor and Lt. Governor.

Commissioner Koller adjourned the meeting at 7:30pm